CHAPTER 38
COORDINATION OF BENEFITS

191—38.1(509,514) Purpose.

38.1(1) The purpose of this chapter is to adopt model group coordination of benefit ("COB") provisions and uniform guidelines for their interpretation and administration as promulgated by the National Association of Insurance Commissioners.

38.1(2) This chapter is intended to establish uniformity in the permissive use of overinsurance provisions to avoid claim delays, duplication of benefits when a person is covered by two or more plans providing benefits for medical, dental, or other care or treatment, and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among plans.

191—38.2(509,514) Applicability.

38.2(1) This chapter does not require the use of overinsurance provisions in group health insurance policies or group nonprofit health service plan contracts. If, however, a policy or contract contains overinsurance provisions, those provisions must be consistent with this chapter. A plan that does not include a COB provision consistent with this rule shall not take the benefits of another plan into account when it determines benefits.

38.2(2) Overinsurance provisions, or provisions for the reduction of benefits otherwise payable because of other insurance by whatever name designated, other than the model coordination of benefit provisions of this chapter may not be used, except that plans of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

191—38.3(509,514) Definitions.

38.3(1) *Plan.*

a. A "plan" is a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the remainder of this subrule.

b. This rule uses the term "plan." However, a group contract may, instead, use "program" or some other term.

c. "Plan" shall not include individual or family:

(1) Insurance contracts;

(2) Subscriber contracts;

(3) Coverage through health maintenance organizations (HMOs); or

(4) Coverage under other prepayment, group practice and individual practice plans; except as provided below.

d. "Plan" may include:

(1) Group insurance and group subscriber contracts;

(2) Uninsured arrangements of group or group-type coverage;

(3) Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(4) Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. This description of group-type contracts is not intended to include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

e. "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

f. "Plan" may include Medicare or other governmental benefits. That part of the definition of "plan" may be limited to the hospital, medical, and surgical benefits of the governmental program. However, "plan" shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan.

g. "Plan":

(1) Shall not be construed to include group or group-type hospital indemnity benefits of $100 per day or less; but

(2) May be construed to include the amount by which group or group-type hospital indemnity benefits exceed $100 per day. "Hospital indemnity benefits" are those not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

h. "Plan" shall not include school accident-type coverages. These cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

38.3(2) *"This plan"* is the portion of the group contract that provides health care benefits to which the COB provision applies and which may be reduced on account of the benefits of other plans.

38.3(3) *"Primary plan."* A primary plan shall mean one in which benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either paragraph *"a"* or *"b"* below is true.

a. The plan either has no order of benefit determination rules, or it has rules which differ from these.

b. All plans which cover the person use the order of benefit determination rules required by this rule, and under those rules, the plan determines its benefits first.

38.3(4) *"Secondary plan."* A secondary plan shall mean one which is not a primary plan. If a person is covered by more than one secondary plan, these order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under these rules, has its benefits determined before those of that secondary plan.

38.3(5) *"Allowable expense"* means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the plans involved.

a. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, as specifically defined in the plan, or in the event the hospital lacks an available semiprivate room for the patient.

b. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

c. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "allowable expense" must include the corresponding expenses or services to which COB applies.

38.3(6) *"Claim"* means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

a. Services (including supplies);

b. Payment for all or a portion of the expenses incurred;

c. A combination of paragraphs *"a"* and *"b"* above; or

d. An indemnification.

38.3(7) *"Claim determination period."*

a. This is the period of time, which must not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine:

(1) Whether overinsurance exists; and

(2) How much each plan will pay or provide.

It usually is a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

b. As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. But that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

191—38.4(509,514) Model COB contract provision.

38.4(1) Following is a model COB provision for use in group contracts. That use is subject to the provisions of subrules 38.4(2) and 38.4(3) and to the provisions of these rules for coordination of benefits.

38.4(2) *Flexibility.* A group contract's COB provision does not have to use the words and format shown in this subrule. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans:

a. Which provide services;

b. Which pay benefits for expenses incurred; and

c. Which indemnify.

Substantive changes are allowed only as set forth in this rule.

38.4(3) *Prohibited coordination and benefit design.* A group contract may not reduce benefits on the basis that:

a. Another plan exists;

b. Except with respect to Part B of Medicare, that a person is or could have been covered under another plan; or

c. A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan defined in 38.3(1) *"a,"* except in accord with rules permitted by 191—Chapter 38.

38.4(4) *Text of the model COB provision.*

COORDINATION OF THE GROUP CONTRACTS
BENEFITS WITH OTHER BENEFITS

I. APPLICABILITY.

A. This coordination of benefits *("COB")* provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one plan.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(1) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefit determination rules, another plan determines its benefits first. The above reduction is described in Section (IV), effect on the benefits of this plan.

II. DEFINITIONS.

A. *"Plan"* is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by

law, its benefits are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under (i) or (ii) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. *"This plan"* is the part of the group contract that provides benefits for health care expenses.

C. *"Primary plan"/"Secondary plan."* The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

D. *"Allowable expense"* means a necessary, reasonable, and customary item of expense of health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, as specifically defined in the plan, or in the event the hospital lacks an acceptable semiprivate room for the patient. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

E. *"Claim determination period"* means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES.

A. *General.* When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of this plan; and

(2) Both those rules and this plan's rules, in subparagraph B below, require that this plan's benefits be determined before those of the other plan.

B. *Rules.* This plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent child/parents not separated or divorced. Except as stated in subparagraph (B)(3) below, when this plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

(c) If the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent child/separated or divorced parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

(4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This para-

graph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

(6) Longer/shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

IV. EFFECT ON THE BENEFITS OF THIS PLAN.

A. *When this section applies.* This section IV applies when, in accordance with section III, order of benefit determination rules, this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) immediately below.

B. *Reduction in this plan's benefits.* The benefits of this plan will be reduced when the sum of:

(1) The benefits that would be payable for the allowable expenses under this plan in the absence of this COB provision; and

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceed those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

(3) When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

A. Certain facts are needed to apply these COB rules. The insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person.

B. The insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the insurer any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT.

A. A payment made under another plan may include an amount which should have been paid under this plan. If it does, the insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan.

B. The insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY.

A. If the amount of the payment made by the insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(1) The persons it has paid or for whom it has paid;

(2) Insurance companies; or

(3) Other organizations.

B. The *"amount of the payments made"* includes the reasonable cash value of any benefits provided in the form of services.

191—38.5(509,514) Order of benefits.

38.5(1) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

38.5(2) A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

38.5(3) Dependent child/parents not separated or divorced. The word "birthday" in these rules refers only to month and day in a calendar year, not the year in which a person was born.

38.5(4) Longer/shorter length of coverage. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include:

1. A change in the amount or scope of a plan's benefits;
2. A change in the entity which pays, provides or administers the plan's benefits; or
3. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

191—38.6(509,514) Reduction in a plan's benefits when it is secondary-general. A secondary plan may reduce its benefits subject to the conditions and limits described herein.

Total allowable expenses. A secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plans benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

191—38.7(509,514) Reasonable cash value of services. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan, and have not already been paid or provided by the primary plan. Nothing in this rule shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

191—38.8(509,514) Excess and other nonconforming provisions.

38.8(1) Some plans have order of benefit determination rules not consistent with this rule which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because a certain plan may not be subject to insurance regulation; or some group contracts have not yet been conformed with this rule.

38.8(2) A plan with order of benefit determination rules which comply with this rule (herein called a "complying plan") may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this rule, (therein called a "noncomplying plan") on the following basis:

a. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.

b. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability.

c. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

d. If the noncomplying plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than they would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan; and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the difference.

However, in no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid. In consideration of such advance, the complying plan shall be subrogated to all rights of the employee, subscriber, or member against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation.

191—38.9(509,514) Allowable expense. A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

191—38.10(509,514) Subrogation. The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

191—38.11(509,514) Effective date—existing contracts.

38.11(1) These rules are applicable to every group contract which provides health care benefits and is issued in Iowa.

38.11(2) A group contract which provides health care benefits and was issued prior to the effective date of these rules shall be brought into compliance by the later of:

a. The next anniversary date or renewal date of the group contract; or

b. The expiration of any applicable collectively bargained contract pursuant to which it was written.

These rules are intended to implement Iowa Code chapters 509 and 514.

[Filed 2/20/87, Notice 12/31/86—published 3/11/87, effective 4/15/87]